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Comment from the Editor

Many pharmacists put the bubbly on ice over the festive period to ensure patients didn't go without vital NHS services. What a kick in the teeth then that the thanks one pharmacy team got for working all hours was to be threatened by armed robbers (p5).

The staff of Rohpharm in Plaistow should have been going home to celebrate a happy New Year at 6.30pm last Wednesday. Instead they were left traumatised after being terrorised with a gun by two degenerates in hoodies.

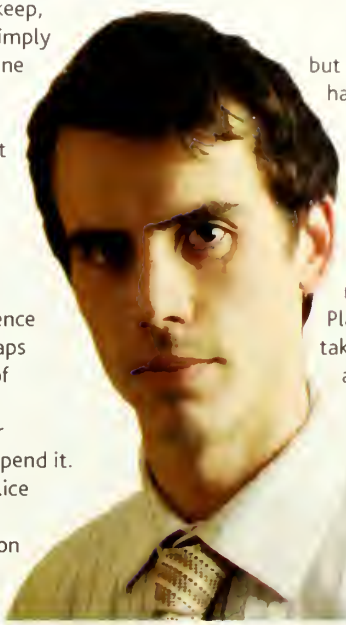
Unfortunately the incident is not unique. No industry is immune to crime and because of their locations in deprived areas and the drugs they keep, pharmacies are more at risk than most. Many simply accept the danger, but the latest victim is not one of them and that could see the case become a cause celébrè. Rohpharm pharmacist Jignesh Patel says that safety in the sector is simply not good enough. Quite rightly he points out that the government cannot expect pharmacies to transform into healthy living centres if staff don't feel safe.

Back in 2004 a series of vicious attacks on pharmacy staff resulted in PSNC factoring violence against the profession into contract talks. Perhaps it's an area to revisit as part of this year's cost of service inquiry.

But even if ministers do pledge more cash for protection then the jury is out on how best to spend it. CCTV and a panic button linked to the local police station couldn't stop the attack in Plaistow.

The NHS offers pharmacists conflict resolution training. This might help sooth customers left seething because you've sold out of Sudafed, but it's unlikely to dissuade a hardened criminal.

> "The government cannot expect pharmacies to transform into healthy living centres if the staff don't feel safe"



With violent attacks against retail staff set to rise as the economy slumps, the industry has to be alert to the dangers. Mercifully nobody was injured during the robbery on New Year's Eve in Plaistow. Let's hope it doesn't take an even worse case for action to be taken.

Max Gosney,
News Editor

Contents

Credit crunch woes predicted

Higher cost of borrowing coupled with cash flow pressures herald an uncertain financial year for pharmacies

Zoe Smeaton

Pharmacists should brace themselves for yet more financial challenges in the first half of 2009, experts have warned.

As the credit crunch tightens its grip on the UK, industry insiders warned that borrowing money from banks is likely to become more expensive. Cash flow will also come under pressure, they predicted.

And while pharmacies in England are set to benefit this month from an increase in practice payments announced last year, experts say these rises may not be enough to keep everyone out of trouble.

Umesh Modi, a specialist financial advisor to pharmacy businesses, said he expected OTC sales to fall in pharmacies, and banks to tighten up on lending. He said: "I think some pharmacies are going to have a challenge – cash flow is going to be tight."

Fin McCaul, chair of the Independent Pharmacy Federation, warned: "For those looking for relief, it's not going to be great."

Others welcomed the extra £280 million in funding secured by PSNC last September as an interim solution to the economic slump. Kirit Patel, chief executive at Day Lewis, said: "The funding has gone a long way to helping. Without that it would have been pretty dire."

But Andy Murdock, superintendent pharmacist at Lloydspharmacy, and Martin Crisp, head of pharmacy at Superdrug, warned that in the future there needed to be equitable funding to help pharmacies develop additional services.

PSNC told C+D it had already begun work towards the cost of service review, which could lead to a new funding model for pharmacy. And Mr Crisp concluded that despite the economic climate, the outlook is "more optimistic" than it had been going into 2008 as the category M changes hit.

The failure of Woolworths could be the precursor to a very tough financial year in many sectors, including pharmacy

2009 concerns

Money worries are at the forefront of the issues facing pharmacy this year, contractors and industry experts have said.

Liverpool LPC secretary Jeremy Clitherow voiced concern about the effect on pharmacy services. He said: "We will have to look at the cost of resourcing the services [the PCT] wants and make business decisions on whether we can go ahead with them."

LPC chiefs in England named implementation of the white paper as a major challenge.

Colleagues in Scotland said the introduction of a chronic medication service was key. In Northern Ireland, pharmacists set their sights on a new contract while Welsh pharmacy chiefs said the profession was primed for an extended health role as NHS reorganisation took place in 2009. **CC**

For more suggestions on what 2009 holds for pharmacy, go to **www.chemistanddruggist.co.uk**

Coughs and colds Christmas boom

Contractors have reported a roaring Christmas trade in cold, cough and flu remedies and prescriptions.

As news of sliding sales and job cuts at leading high street retailers filled the national press this week, pharmacy owners told C+D they had had a "busier than average Christmas" due to a surge in winter ailments.

Martin Bennett, of Sheffield's Wicker Pharmacy, said he had treated more minor ailments than ever. Warren England, of Wigan's England Pharmacy, dealt with more prescriptions than a normal festive season, and been "cleared out" of cough and cold remedies.

But even with the high footfall from winter ailments, there had "certainly been a slow down in retail trade", said NPA business manager Raj Nutan. He advised contractors to speak to their suppliers about special offers and point of sale material on OTC cold and flu remedies and vitamins. Mr Nutan also hoped new year's resolutions to quit smoking and lose weight would "bring people back into the pharmacy".

Scottish Borders-based Romanes Pharmacy's Christmas retail sales "kept pace" with last year's figures. Contractor George Romanes said: "People are shopping more carefully but the picture was fairly reasonable considering all the doom and gloom."

Despite the good news from the festive period, NPA members remained "worried about the economic climate and cash flow", Mr Nutan said. **JR**

C+D launches free online recruitment service

Chemist+Druggist has this week launched a free online recruitment service to connect pharmacy job seekers and employers.

C+D Jobs is set to become the place for job seekers to search for pharmacy positions free of charge, at www.chemistanddruggist.co.uk/jobs. And the service is offering employers free online listings for a limited time.

Improved search functionality will be added to the site in the coming months, including the facility for both employers and interested potential employees to see how much interest a particular job advert has attracted.

Readers will be alerted by email to new job listings, including the 'Job of the Week', and careers advice. Visit www.chemistanddruggist.co.uk/register to sign up. And complete the jobs survey at www.chemistanddruggist.co.uk/jobs to be entered into a prize draw to win an iPod Classic.

To advertise a position, employers should contact Jonathan Franklin on 020 7921 8333.

Turn to pages 24/25 for the new C+D Recruitment section. **JR**

C+D Jobs

An east London pharmacist is still in shock after being held up at gunpoint on New Year's Eve. Rohpharm in Plaistow was preparing to close at around 6pm when two masked robbers threatened staff with a gun concealed in a carrier bag. Although the pharmacist Jignesh Patel (pictured) triggered the panic alarm, the robbers escaped with the till and its contents. No drugs were taken and nobody was harmed in the incident. However, the attack had undermined staff safety, Mr Patel said. The profession needed greater support with security, he added. Mr Patel said: "We need to feel secure to actually provide services, and if the front-line staff actually don't feel secure, you don't have the support staff for you to carry on with enhanced services." Spokesman for the PDA John Murphy recommended employers regularly assess their security arrangements. "A lot could be done to help pharmacies have better arrangements," he commented. Flying Squad detectives are appealing for witnesses and information. CC

Timing right for obesity services

Pharmacists should think about offering weight management services to tie in with the government's new obesity campaign, experts have said.

But others warned that for progress to be made, a national enhanced service template must be adopted quickly.

The government has launched its Change4Life advertising campaign to tackle obesity by encouraging healthy eating and active lifestyles.

Alastair Buxton, head of NHS Services at PSNC, said PCTs would have to incorporate the anti-obesity measures as part of their public health strategies, which could "open the door" for pharmacy weight management services.

The campaign comes as the final report of the award-winning pharmacy-led weight management programme in Coventry was published, demonstrating an effective pharmacy service. The pilot saw more than a quarter of participants achieve a 5 per cent or more weight loss, and the mean change in weight of patients was statistically significant.

Mr Buxton said the results could provide a useful evidence base for pharmacists trying to get services commissioned.

But Dr Terry Maguire, a pharmacist in Northern Ireland who was involved in developing the Coventry programme, said that to progress, a service specification needed "to be adopted UK wide".

The Coventry programme has now been taken up by Plymouth and Cornwall & Isles of Scilly PCTs and PSNC hopes to complete an obesity service template "soon". **ZS**

Cumbria service assists quitters

Around 65 pharmacists across Cumbria have launched a smoking cessation service, commissioned by the local NHS, in time to help new year quitters.

Pharmacies are paid up to £20 per patient to provide the service, which includes an initial half hour consultation and ongoing support over a 10-week period. Nicotine replacement therapy is supplied under a patient group directive, and pharmacists or staff attended training for the service.

Pharmacies have received help with marketing the service and have support from local specialist anti-smoking clinics. **ZS**

C+D's CPD Knockout winners get £800

First places and cheques for £800 go to Maggie Vesty (Oxford), Margaret March (Weston-super-Mare), Raj Patel (Kingston), Vivek Kuvelker (Stockton on Tees) and Trevor Purrington (Oxford).

Second places and cheques for £500 go to Rosemary Blackie (Sheffield) and Sheila Castle (Truro).

Congratulations to the winners, and to many of the entrants who did so well this year in C+D's CPD competition.

As many as 35 of you made it through to the exam stage.

Special mention must go to Rosemary Blackie, who completed Update 2008 and the final exam in adverse circumstances and still managed to get full marks.

Congratulations to you all. Cheques are in the post, with thanks to our sponsor, Genus Pharmaceuticals.

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A full list of Knockout finalists and their scores can be found on the C+D website at www.chemistanddruggist.co.uk/update

Sign up now for Update 2009 This year you have the choice of being marked either online or by telephone – and, even better, we're now offering an online log for your CPD.

To get your RPSGB-approved CPD certificate, simply complete the CPD exercises and answer the 5 Minute Test online.

Turn to page 15 to learn more.

News in brief

Supply chain consultation

The MHRA has launched consultation on proposals to strengthen the UK medicines supply chain and reduce the risk of counterfeit medicines. http://tinyurl.com/9fbhry

Ranbaxy settlements

The Scottish Government and Northern Ireland Executive have agreed settlement of claims against manufacturer Ranbaxy over alleged anti-competitive conduct in the supply of generic drugs to the NHS. Ranbaxy has agreed to pay, on a full and final basis and without admission of liability, £1,057,500 and £352,500 respectively.

Pharmacy for flu and colds

NPA chief executive John Turk has urged people to seek advice on colds and flu from their local pharmacy after increased demand on other healthcare providers due to minor ailments was highlighted.

Script sorting

NHS Prescription Services has introduced a revised form for the submission of prescription bundles for pricing, to clarify sorting requirements under the automated scheme. The new FP34c document will be supplied from this month with optional red separators for sorting broken bulk and calendar pack scripts.

Prescription clarification

Prescriptions signed by the prescriber are legally valid even if the name printed below the signature is not that of the prescriber, PSNC, the RPSGB and NHS Prescription Services have clarified. PSNC has also issued guidance on the submission of prescriptions for the product Sharpsguard (formerly Sharpsbin), and Easter opening hours. www.psnc.org.uk

Obituary

GSK Consumer has announced the sudden passing of Peter Hollingworth, who had been a territory business manager for its pharmacy field force for 35 years. The company added: "He always approached his role with great professionalism but also with great personality and humour and he will be sadly missed."

Clinical Briefs

Nice rule change

Nice appraisal committee members have been given new criteria for recommending treatments for patients near the end of life. Nice usually only recommends treatments that cost less than £30,000 per quality-of-life-year (QALY). However, having taken account of social factors, conducted a consultation and taken advice from its Citizen's Council, the appraisal agency has now adopted a new set of rules for patients near the end of life who meet certain criteria.
http://tinyurl.com/9ztupy

Antifungal asthma relief

Many asthma sufferers may benefit from treatment with the antifungal itraconazole, University of Manchester scientists have claimed. Their research, published by the American Journal of Respiratory and Critical Care Medicine, showed that as many as 60 per cent of a group of patients with severe asthma who tested positive for fungal allergies later showed significant benefits after taking the antifungal.
www.safs.org.uk

Fish oil findings

A BMJ review of 12 randomised controlled trials of fish oils has concluded there is insufficient evidence to recommend an optimal formulation of two key fish oils. Docosahexaenoic acid (DHA) and eicosapentaenoic acid (EPA) were associated with a significant reduction of deaths from cardiac causes, but had no effect on arrythmias or all-cause mortality.
http://tinyurl.com/a982jx

Hormone bone loss link

Adolescent girls using depot medroxyprogesterone acetate may be at risk of losing bone mass, according to researchers writing in the journal Fertility and Sterility.
http://tinyurl.com/7gxswt

QOF points boost health

Incentivising GPs through the QOF system may be improving glucose levels in patients with diabetes, according to study results published by the journal Diabetes Care.
http://tinyurl.com/9wstvf

Northern Ireland peace after minor ailments row

Pharmacy leaders achieve £1 million in extra funding for scheme

Max Gosney

Northern Irish pharmacies have ended their boycott of minor ailment services after industry leaders secured £1 million extra funding for the scheme.

Contractors will now be paid for treating up to 2,250 patients a year – almost double the threshold originally proposed by health ministers.

Pharmacists will get £10.04 for each of the first 500 patients treated under the latest deal. All additional consultations will be paid from £6.54 to £9.04.

Pharmacists quit the scheme last August in protest at government plans to limit the sector to 1,300 patient consultations per year.

The revised package signalled a "fairer and more reasonable" arrangement, according to the Pharmaceutical Contractors Committee (PCC).

The agreement could also revive stalled contract negotiations in Northern Ireland, PCC chief executive Terry Hannawin told C+D. He said: "We're extremely pleased to reach an agreement... it's an important first step in the evaluation of the new contract for pharmacy."

The revised service will be reviewed next year under the deal agreed between PCC and health ministers.

Northern Ireland's Department of Health has maintained the right to mystery shop pharmacies offering the service.

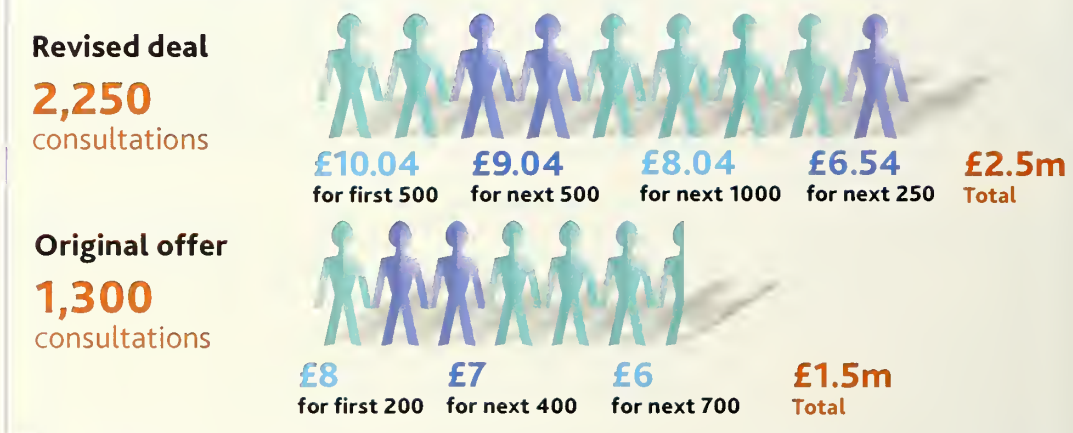
However, inspections would only be carried out when contractors were linked to poor practice, according to PCC.

Local pharmacists applauded the deal. John Hamill, pharmacy manager at McMullans Pharmacy in Belfast, said: "It's a great deal and reflects the time and effort pharmacists put in to run the service. It shows we are a force when we stand united."

Oonagh McElhinney, of Bradbury Pharmacy, Belfast, added: "It's a sad thing that we had to dig our heels in to be recognised. But I'm pleased pharmacy took a stand."

What do you think of the new deal?
mgosney@cmpmedica.com

How the deal compares



Pill mix-up not responsible for pregnancy

A pharmacist blamed for causing an unwanted and "torrid" pregnancy through a dispensing error has been cleared by a High Court judge.

Louise Wootton, from Walsall, argued that she fell pregnant with a daughter, born in May 2004, because a locum pharmacist had dispensed the wrong contraceptive pill.

Mrs Wootton was given Logynon ED when she had been prescribed Microgynon ED and conceived shortly after taking it. She claimed damages for care, expenses and loss of earnings after the pregnancy and a period of post-natal psychosis.

Mrs Wootton's lawyers said she should have won on the basis of expert evidence that changing from one oral contraceptive pill to another increases the risk of pregnancy.

But Lord Justice Moses dismissed the appeal, ruling that in taking two Logynon tablets, Mrs Wootton had not changed from one contraceptive to another, but had "merely reduced the level of one of the two hormones supplied, progesterone, by 100mcg or, at most, 200mcg".

He added: "The appellant has failed to establish that the erroneous intake of two Logynon pills materially increased the risk of contraceptive failure."

Mrs Wootton had originally sued J Docter Ltd, the firm contracted to provide pharmaceutical services at the pharmacy involved. It was acquitted of negligence, but Mrs Wootton challenged the judge's finding that the pharmacist's error had not caused her pregnancy in the eyes of the law. **UKL**

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EPS release 2 is set to arrive this year. But we've heard it all before, so is it really true, and why has the project taken so long? **Zoe Smeaton** finds out

Please release me

When electronic prescriptions were first discussed, it was expected that pharmacists would be reaping the benefits by now. The Department of Health said eight years ago that, by 2004, electronic prescriptions would be "routine in the community" and by 2008 "or even earlier", the transfer of prescription data would be electronic "in the large majority of cases".

Fast forward to the present, and all eyes are on release 2 of the electronic prescription service (EPS), which will remove paper prescriptions completely and is expected to be piloted early this year. But this is a revised date, having been put back several times, so what has been causing all the delays and is it ever really going to happen?

Asked why the process has taken so long, Connecting for Health (CfH), the government agency charged with delivering the project, says: "It has always been anticipated that there will be a variability in the time taken for suppliers to have release 2 compliant systems in place."

The suppliers themselves point the finger back at CfH, saying developing the EPS systems has been complex. They claim targets and service specifications have been changed throughout the process, and they have sometimes failed to get prompt feedback from CfH. One previously likened the agency's system approval process to "swimming through treacle".

Their problems have been evident as many suppliers have been forced to increase customer prices to cover the development work, and others are set to follow suit next year. One supplier, Torex, has also decided to withdraw from the process altogether.

And even when the pharmacy systems are complete, the suppliers are "not masters of their own destiny", says Martin Jones, commercial manager at Positive Solutions. This is because they must also wait for a GP system to be ready in order to run the first release 2 tests.

Lack of engagement by pharmacists themselves may also have been slowing down development of the systems. Many complain systems are slow, so they are reluctant to use them. But unless the technology is tested, the systems cannot be improved. As Beran Patel, of Brigstock Pharmacy in Croydon, says, many pharmacists still haven't "got themselves organised in [obtaining] the systems and testing them out".

With everyone refusing to take responsibility and laying the blame elsewhere, working relationships have been an issue. Early last year C+D (March 15, p12) suggested the time had come to work together to move the project forwards and ensure EPS is workable. Yet recent moves by the pharmacy professional bodies have done little to ease the tensions. While many are working to help promote EPS and ensure it runs smoothly for contractors, the system suppliers say some of their tactics have not been helpful and that their concerns are coming too late.

> "A supplier likened the system approval process to 'swimming through treacle'"

The pharmacy bodies recently jointly raised concerns about the benefits and practicalities of EPS to the DH. As UniChem head of customer IT Mark Johnson says, this meeting had "looked like it was all coming together". However, the details have been kept secret, raising suspicions among system suppliers.

Simon Driver, managing director of Cegedim Rx, says the move simply asks more questions. He says: "I think they've caused more concern than they have alleviated."

Others feel the meeting with the DH is too little too late and that the pharmacy bodies are behind the times. As Mr Jones says of EPS: "The train left that station a while ago and they're still on the platform. It would have been a lot more effective if we had had the conversations we are having now four years ago."

So with many issues still remaining, and relationships fraught, are we ever going to get there? The government certainly thinks so, as it has recently issued statutory directions enabling some PCTs to go live with EPS release 2 when the systems are ready.

And Mr Jones says it quite simply has to, because if the brakes are applied it would be "disastrous" financially for the suppliers, after spending so much working towards it. He also says it needs to happen for the profession, as linking pharmacists up to the NHS electronically will be a vital step in enabling them to take on the clinical roles of the future. For example, he says if pharmacists are to carry out vascular screens, other health professionals are not likely to want all the results coming in "on a piece of paper" in years to come.

He predicts all may not run smoothly though, and suggests the main parts of release 2 will go ahead, but complexities may have to be worked in at a later date. "I think there will be an EPS 3 and 4. There is going to have to be an outbreak of pragmatism, and we'll go for the main part of EPS 2 but there will be complexities that need to be parked and picked up on later."

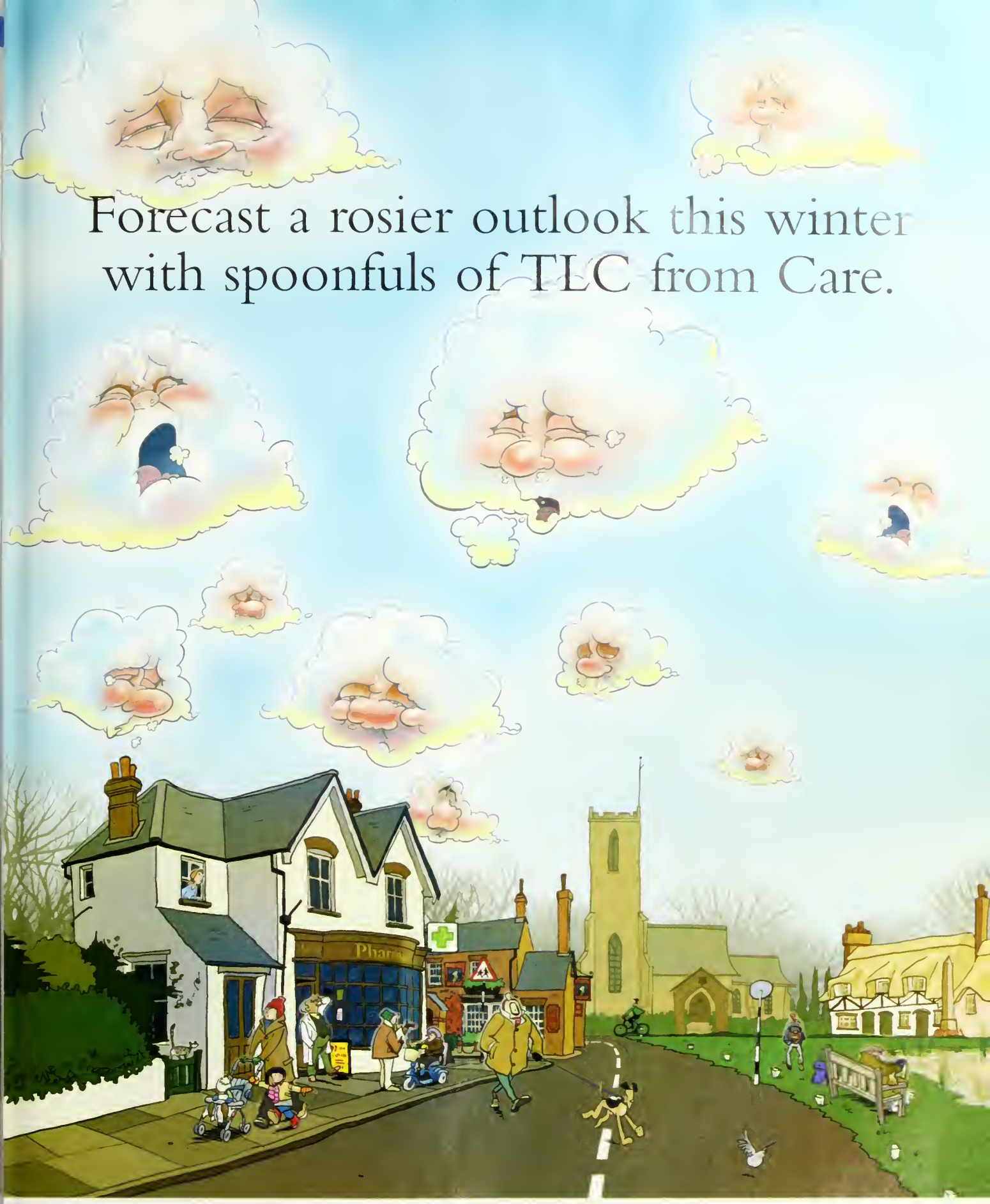
So it seems EPS will have to happen at some stage, although it might require closer relationships between the stakeholders to be developed. But while most are frustrated by the delays and point the finger at others, perhaps it's time to look for some positives. For one thing, we need to be certain the system is going to work, and that unavoidably takes time.

As Ian Taylor, commercial director at Rx Systems, says: "It's taken a long time to get where we are now for lots of reasons, but the vast majority [of those] are valid." Perhaps it is better to get there properly than to get there quickly.

Have you got faith in EPS? Send us your views
zsmeaton@cmpmedica.com

Next week:
how to use IT to develop your business

Forecast a rosier outlook this winter with spoonfuls of TLC from Care.



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Xrayser

What's your view? haveyoursay@cmpmedica.com

Don't force me to be popular

The government wants patients to be able to rate their GP's performance via bulletin boards on the NHS Choices website. Doctors think this is a bad idea and I agree.

I'm all in favour of patient empowerment, but unless they've spent 10 years training they're not qualified to criticise a GP's clinical skills. By all means let them comment on waiting times or premises, but an online selection of personal opinions about individual GPs will only serve to spread yet more disinformation and confusion.

Amazon was cited as an example of what can be achieved from user reviews, but whether a reader enjoys a book is purely down to the standard of the publication. Patients' perception of their heart disease or cancer treatment involves a range of highly subjective and emotional indicators that are unhelpful to anyone else.

Even Amazon reviews must be taken with a pinch of salt, because the individual with the time and inclination to write 1,000 considered words on a piece of chick lit is not 'Mr Average'. Likewise, online GP reviews are more likely to be written by sociopaths with Munchausen's syndrome than an average Joe with similar expectations to your own.

> "I would feel under pressure to lower my standards of clinical care simply to get more positive reviews"

This is political gimmickry aimed at the young middle classes, who are probably the lightest users of the NHS anyway. The elderly, disabled and poor are unlikely to bother with this sort of exercise.

And how useful are comments from Mr Average, if he's persuaded to make any? Consider this submission to the Shipman inquiry: "I remember the time Shipman gave to my Dad. He would come round at the drop of a hat. He was a marvellous GP apart from the fact that he killed my father."

But my main concern is that the scheme could be extended to community pharmacists. Apart from being forced to be unnecessarily pleasant to people I can't stand, I would feel under pressure to lower my standards of clinical care simply to get more positive reviews.

Much of my best work is based on telling patients what they don't want to hear: "You shouldn't really take those three paracetamol-containing preparations together," or, "have you considered stopping smoking/losing a little weight?", aren't exactly vote winners. Let the public vote on things that don't matter, like the best X Factor performance, but they must not be allowed to judge healthcare professionals in this manner.

I'm happy for patients (mad, bad or simply confused) to comment on my pharmacy premises, waiting times, or the suitability/standard of enhanced services, but if they don't like what I'm saying they should simply ask another pharmacist (who will hopefully say something similar).

We are already subject to more than enough scrutiny by people supposedly qualified to make objective comments. Politicians have to be popular to win elections, we shouldn't have to.

Irish eye

Terry Maguire

Put in our place – at the heart of healthcare

During Christmas week I became mildly famous in West Belfast. A Building the Community Pharmacy Partnership project reached its conclusion with the public unveiling of a youth anti-drugs and alcohol mural on the wall of the pharmacy. Our chief pharmacist, who is always mistaken for Gerry Adams MP when he visits, was one of the high profile dignitaries who spoke on the benefits pharmacies bring to the local community.

We all appeared on page three of the local newspaper and over the page I featured again, this time for an off-the-cuff comment I had made to a journalist at the unveiling ceremony. I flippantly distinguished flu from the common cold as a condition that is so severe you would be unwilling to get out of bed to lift a £50 note off the bedroom floor. This article was picked up by local radio and seemed to provide an insight on viral infections that was previously lacking. The next day BBC TV followed up with a serious interview on the potential fatal consequences of flu.

The day after that TV cameras were back in the pharmacy, this time seeking comment on the Northern Ireland Minor Ailments Scheme (NI MAS). This is indeed a good news story and congratulations and thanks to PCC for securing an excellent deal. The NI MAS was reintroduced on January 1 following five months of hard negotiation. It is a much better deal than that first proposed by DHSSPS in July; now a ceiling of 2,250 items per year as opposed to 1,300 and an increase in intervention fees. The new service extends beyond coughs, colds and sore throats to cover a total of nine areas, including head lice, diarrhoea and fungal infections etc. And of course, in an attempt to catch all the New Year resolutions, I am currently advertising our smoking cessation service in the local newspaper, adding further to my fame.

I never look forward to on-call Christmas Day and Boxing Day but this year I was exceptionally busy, particularly on Boxing Day, and that at least made it worthwhile. Over 80 per cent of prescriptions were for flu-like symptoms, reflecting the unusually high viral infection rates across Belfast for the time of year. Of these prescriptions the majority were for OTC medicines: simple analgesics and cough syrups – medicines for conditions that do not require the patient to see the GP. Out-of-hours GPs have got the message and no longer award patients with a course of antibiotics simply for attending their clinics. Even the public are now shunning antibiotics unless really necessary and credit must go to government campaigns that have effectively re-educated the population. How much more I could have done on my Christmas on-call sessions had the minor ailments service been active and properly advertised.

That said, these services really do put community pharmacy at the heart of healthcare and I am greatly encouraged that 2009 will see the implementation of a new contract benefiting the profession, the public and the health service.

Terry Maguire is a community pharmacist in Northern Ireland

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Letters

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Or write to the Editor at:

C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE

Letters may be edited for content and length

Joint effort is best outcome for patients

Certain parties seem intent on provoking a turf war between GPs and pharmacists over the vascular checks programme.

This is a great shame since both PCTs and GPs are, in fact, increasingly open to the role that pharmacy and other alternative providers can play in the programme.

Indeed, doctors' leaders have told us they see an important role for pharmacy in the programme, particularly in under-doctored areas and for hard-to-reach groups. It would be a lost opportunity if PCTs were to pursue a single channel when common sense dictates that a co-ordinated offering involving both GPs and pharmacy would deliver far greater results for patients.

In 2007 Lloydspharmacy showed just what can be achieved by performing health checks on 10,000 men in Birmingham's most deprived wards. Many of these men had not been to see their GP for decades. Sixty five per cent of those checked were referred for further investigation and more than 75 per cent said they intended to make lifestyle changes as a result.

Andy Murdock, pharmacy director, Lloydspharmacy

Andy Murdock: GPs and pharmacy should work together

Bureaucracy getting in the way of patient care

I hardly need to repeat all the problems that many contractors are having with the Prescription Pricing Division (PPD) – suffice to say I am extremely frustrated and have zero confidence – but I have a new issue to add to the list.

Instead of receiving prescriptions for re-submission in the month following dispensing, I now receive them a month later, thus delaying payment to me. This seems to be of little concern to the PPD and I have been informed this will continue for a while as they are "very busy"!

This seems to be a continuing problem with an ever-increasing burden shifting from PPD staff to contractors – the only improvement their programme seems to have made is to reduce their costs. The Pharmaceutical Services Negotiating Committee (PSNC) has been of little or no help and is far too submissive to the PPD.

> "The attitude that they can complete their work when it suits them is a step too far"

We have had to tolerate a drop in standards for too long already, but I believe the attitude that they can complete their work when it suits them with no regard to our cashflow is a step too far.

I believe all contractors should now demand a rise in standards of accuracy, efficiency and customer service; and we must pressure PSNC to force the PPD to achieve this.

Maybe then we will be able to concentrate on patient care rather than solving problems created by the PPD.

Tajinder Singh MRPharmS, Totley Pharmacy, Sheffield

Time for PPD and PSNC to come clean

Further to the debate and articles in C+D about the PPD's new business processes, I'd like to add we have been monitoring our account since we were switched to the new scanning pricing process and queried our January payment in April via the PSNC.

We have finally had our report and were underpaid 5 per cent. The biggest issue is the missed items: 96 in total, which in our case is 1 per cent of the total submitted. This, however, has equated to a loss of 5 per cent in reimbursement.

Therefore, perhaps PSNC and the PPD need to come clean that the error rate is higher than published and a one-off payment of 5 per cent of the total reimbursement since switching to the new pricing process should be paid to all contractors!

Name and address supplied

Last words on the subject

Yes my friends, the end is near as I hang up my white coat – not that I've worn one for several years as I am in the smart tie and shirt brigade. But before I shuffle off, I'd like to make a few observations.

- MURs: these should be doctor initiated by marking scripts that one should be carried out, leading to less bum fodder.
- Two hours' absence: the proposal to allow pharmacists to leave the premises for two hours is a backward step, and could lead to misuse. And what about the 'Ask your pharmacist' campaign? Will staff respond: "Yes madam, come back in two hours!"
- CPD: this has more convolutions than a rat's nest. I once attended a lecture in Bolton given by an expert on CPD. We were handed questionnaires on what action should be taken in different scenarios. For question one she thought it would be 'Action' but it was 'Reflection'. If she was pondering, what chance have we mere mortals?

Harry White MRPharmS, Atherton, Manchester

Can't take that away from me

As I read it (The New Professional Body for Pharmacy – The Prospectus, p21): "If you are not a practising pharmacist... it will not be legally permissible to call yourself a 'pharmacist'."

At present I, together with many others, call myself a non-practising pharmacist. Where will we stand?

As for the use of post-nominal letters, I think I will have to fall back on my BSc (Pharmacy) and to styling myself as a 'pharmaceutical chemist'. After all, as the song says: "They can't take that away from me."

Leslie Cope MRPharmS, Walsall

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C+D Clinical

What's new in type 2 diabetes?

What the new diabetes drugs bring to management, and other topical issues in diabetes

60-second summary

- **Which of the new treatments can be added if control is inadequate with metformin and/or a sulphonylurea?** Of the newer drugs, exenatide can be considered for dual or triple therapy but is not licensed for use with glitazones. Sitagliptin and vildagliptin are licensed for dual therapy with metformin, a sulphonylurea or a glitazone. However, only sitagliptin is licensed as triple therapy with both metformin and a sulphonylurea.
- **Are there any drawbacks?** Long-term data are not available for the new diabetes drugs. With exenatide there are concerns about possible links with pancreatitis and cancer. A Cochrane review suggested gliptin use should be restricted until there is more safety data; liver function tests are needed with vildagliptin, and increased infections (suggesting an effect on the immune system) have been seen with sitagliptin.
- **How safe are the glitazones?** Rosiglitazone is now contraindicated in acute coronary syndrome and not recommended in ischaemic heart disease or peripheral arterial disease. If a glitazone is deemed necessary, pioglitazone is probably a safer choice.

Claire Jones MRPharmS

Type 2 diabetes patients need additional therapies over time to maintain glycaemic control. This article discusses the new add-on drug treatments, compares side effects of glitazones, and explains the latest thinking on how tightly glucose levels should be controlled and whether self-monitoring is worthwhile.

Updated Nice guidance on type 2 diabetes management was published in May 2008, but is outside the scope of this article and is summarised in recent MeReC publications.

Reflect

How effective is exenatide compared to insulin in type 2 diabetes? What are the latest recommendations about prescribing glitazones? Is it important for people with type 2 diabetes to self-monitor their glucose levels?

Plan

This article describes the latest treatments for type 2 diabetes, including their advantages compared to established blood glucose lowering drugs, and the side effects and complications they may cause. Other topical issues in type 2 diabetes management are also discussed.

CPD This article (Module 1459) can help in the following CPD competencies: **G1a, G1c, G1f, C1a, C1b, C3e**. See http://tinyurl.com/68ox7b

The exact place of the new diabetes treatments in management is not know, not least because long-term data is not yet available

New drugs

Intestinal hormones known as incretins stimulate post-prandial secretion of insulin. In type 2 diabetes the incretin response to food ingestion is attenuated and so new drugs have been developed – the dipeptidyl peptidase-4 (DPP-4) inhibitors and exenatide – to enhance incretin activity.

Exenatide

Exenatide (Byetta) is licensed for subcutaneous injection as either dual therapy in combination with metformin or a sulphonylurea, or as triple therapy in combination with both metformin and a sulphonylurea, in adults with type 2 diabetes and inadequate glycaemic control on maximally tolerated doses of these oral therapies. The drug is administered using a pre-filled pen device that delivers 60 doses of either 5 or 10 micrograms. A starting dose of 5 micrograms twice daily for at least one month is recommended to improve tolerability. This may then be increased to a maximum of 10 micrograms twice daily. It should be administered within an hour before morning and evening meals (and not injected after a meal).

Published randomised controlled trials have evaluated the effect of exenatide on HbA1c levels in patients with type 2 diabetes compared with either placebo or insulin. HbA1c is a measure of glycosylated haemoglobin and indicates how high the blood glucose has been on average over the preceding eight to 12 weeks. Normal non-diabetic HbA1c is 3.5 to 5.5 per cent, while updated Nice guidance generally recommends a target HbA1c level of 6.5 per cent in diabetes.

Comparisons of exenatide 5 to 10 micrograms twice daily against placebo (in patients inadequately controlled on a sulphonylurea, metformin, or both) over 30 weeks showed a fall of about 0.5 to 1 per cent in HbA1c levels with exenatide compared with an increase of 0.1 to 0.2 per cent with placebo.

In patients inadequately controlled on a sulphonylurea and metformin, the addition of exenatide has been compared with adding insulin glargine or aspart. Insulin doses were adjusted to achieve optimal glycaemic control, while exenatide has the advantage that intense glycaemic monitoring is not required. The trials showed similar falls in HbA1c levels of about 1 per cent with exenatide and with insulin. Unlike insulin, exenatide is more likely to be associated with weight loss than weight gain. More patients withdrew from the exenatide group than from the insulin group, however.

The most frequent unwanted effects with exenatide are nausea (in up to 57 per cent of patients) and vomiting (in up to 17 per cent), hence the 5 micrograms starting dose. Hypoglycaemia can occur and, in trials, has been more common in patients also taking a sulphonylurea. The SPC for Byetta states that when it is added to sulphonylurea therapy, a reduction in the sulphonylurea dose should be considered to reduce the risk of hypoglycaemia. In addition, exenatide slows gastric emptying and has consequences for co-administration of lovastatin (C_{max} is lowered) and warfarin (there are reports of raised INRs).

So what could be its place in therapy? The recent Nice clinical guideline does not recommend exenatide for routine use. However it may be considered as an option in patients who are obese (BMI over 35kg/m^2) with specific problems arising from their obesity and with inadequate glycaemic control (HbA1c level 7.5 per cent or more) despite metformin and sulphonylurea therapy, and who would otherwise be considered for expensive add-on therapy such as insulin or a glitazone.

Exenatide may therefore be seen as an alternative to starting insulin in some patients who are inadequately controlled on metformin and/or sulphonylureas. However, it is not licensed for use with glitazones, and clinical trials have not explored its use in triple therapy with oral hypoglycaemics. Unlike insulin, exenatide does not require frequent blood glucose monitoring or continual dose titration, but long-term mortality and morbidity data are not yet available. Reports of pancreatitis and concerns over a potential link with cancer are emerging, and in any case the treatment is seen as an expensive option.

DPP-4 inhibitors

Sitagliptin (Januvia) and vildagliptin (Galvus) are other options for add-on treatment of type 2 diabetes. Some excellent independent reviews are already available, not least from the Drug and Therapeutics Bulletin and the Cochrane Collaboration.

Sitagliptin 100mg daily with or without food is licensed as dual therapy, in combination with metformin, a sulphonylurea, or a glitazone; or as triple therapy with metformin and a sulphonylurea in adults with type 2 diabetes. Vildagliptin is licensed for dual therapy with metformin, a sulphonylurea, or a glitazone in adults with type 2 diabetes. When used with metformin or a glitazone, the dose is 50mg twice daily (again with or without food). With a sulphonylurea, the dose is 50mg in the morning. Vildagliptin is not licensed as triple therapy.

A Cochrane review of 25 good quality studies found that, compared with placebo, sitagliptin and vildagliptin resulted in an HbA1c reduction of about 0.7 per cent and 0.6 per cent, respectively, over 12 to 52 weeks. There is currently no published data on mortality, diabetic complications and health-related quality of life. Comparisons with active comparators are limited but indicate no improved metabolic control following gliptin intervention compared with other hypoglycaemic agents.

Overall sitagliptin and vildagliptin were well tolerated with no severe hypoglycaemia reported. They did not cause weight gain. Headache was more common with gliptins compared with control therapy. All-cause infections increased significantly after sitagliptin treatment but did not reach statistical significance following vildagliptin. Gliptins inhibit DPP-4 which, as well as breaking down incretins, is responsible for the breakdown of peptide hormones in the immune system.

Hepatic dysfunction has been reported rarely with vildagliptin – hence the need for liver function tests at start of therapy, every three months in the first year and periodically thereafter.

So what is their place in therapy? The Cochrane review concluded that gliptins had no advantages over other established blood-glucose-lowering drugs, and that their use should be restricted until long-term data on cardiovascular outcomes, safety (especially the effect on immune function), diabetic complications and all-cause mortality are available.

Risks of glitazones

Over the past year there has been much publicity on the cardiovascular risks associated particularly with rosiglitazone. It is now well established that there is an increased likelihood of fluid retention and congestive heart failure with glitazones, particularly when insulin is also used. Indeed the SPCs of pioglitazone and rosiglitazone contraindicate their use in patients with current or previous heart failure, and recommend that all patients taking these drugs should be monitored for adverse effects relating to fluid retention.

What has also emerged, following several large meta-analyses in 2007, is that there is an increased risk of myocardial infarction with rosiglitazone compared with control therapy, although there is no significant increase in the likelihood of cardiovascular death. In April 2008, a Drug and Therapeutics Bulletin concluded that if a glitazone is thought to be necessary then pioglitazone is probably the safer choice. In addition, some regional drug and therapeutics committees (eg MTRAC, which publishes advice for GPs in the West Midlands) no longer recommend rosiglitazone because of these concerns.

In February 2008 a Drug Safety Update from the MHRA stated that new warnings would be added to the product information for rosiglitazone-containing medicines. Rosiglitazone is now contraindicated in patients with acute coronary syndrome (such as angina or some types of MI), and is not recommended for patients with ischaemic heart disease or peripheral arterial disease.

Self-monitoring – is it worth it?

The view that routine self-monitoring of blood glucose (SMBG) is unlikely to be beneficial in patients with type 2 diabetes who are not treated with insulin has been reinforced by two studies published in the BMJ in 2008. The ESMON study found that people with newly diagnosed type 2 diabetes are unlikely to gain additional benefits from monitoring their blood glucose themselves. Adding SMBG (with advice and guidance on how to respond to high or low readings) to a comprehensive, structured education programme did not affect glycaemic control (ie HbA1c) compared with the education programme alone. No differences were found between groups in the incidence of reported hypoglycaemia, use of oral hypoglycaemic drugs or change in body mass index.

The DiGEM economic analysis showed that, in patients with non-insulin treated type 2 diabetes, intensive SMBG approximately doubled the net costs of monitoring, with no improvement in glycaemic control. This was accompanied by a decrease in quality of life (eg there was limited evidence that SMBG adversely affected the emotional state of patients).

The updated Nice guidance on type 2 diabetes published in May 2008 recommended SMBG should be offered to people newly diagnosed with type 2 diabetes as an integral part of self-management education, when the purpose is clear and the patient understands how results should be interpreted and acted upon. Nice recommends that SMBG should be available to:

- those on insulin
- to those on oral glucose-lowering medications to provide information on hypoglycaemia

It should be used to assess changes in glucose control resulting from medications and lifestyle changes, monitor changes during illness and ensure safety during activities, including driving.

Glycaemic control – how low do we go?

Two studies of intensive versus standard therapy (ACCORD and ADVANCE), published in the New England Journal of Medicine in 2008, were unable to identify a significant improvement in patient-orientated outcomes with intensive therapy. Details are in the full version of this article on the website at www.chemistanddruggist.co uk/update.

The updated Nice guidance generally recommends a target HbA1c of 6.5 per cent and cautions against the use of highly intensive management strategies to achieve lower levels (in line with the trial results above).

In addition, these studies emphasise the fact that treating patients with type 2 diabetes is not simply about reducing their blood sugar but, more importantly, about reducing their risk of cardiovascular disease with smoking cessation, treatment of high blood pressure, lipid modification and anti-thrombotic therapy. Again, this multi-targeted approach is reflected throughout Nice guidance.

Claire Jones is a community pharmacist carrying out consultancy work. Previous posts include former assistant head of NHS development, National Pharmacy Association, pharmaceutical adviser and National Prescribing Centre trainer.

References are online at www.chemistanddruggist.co.uk/update

Your Continuing Professional Development

CPD

Act

- Read the full version of the section 'Glycaemic control – how low do we go?' in this article on the C+D website at www.chemistanddruggist.co.uk/update
- Revise your knowledge of the signs and symptoms of type 2 diabetes at NHS choices http://tinyurl.com/667zeo
- Update your knowledge of the treatments for type 2 diabetes in the BNF, section 6.1. Revise the doses, cautions and side effects for the drugs mentioned in this article.
- For more information on HbA1c (glycosylated haemoglobin) and its importance read the explanation on the Diabetic Retinopathy website http://tinyurl.com/62ufuo
- Do you have many patients taking glitazones? What advice could you give them if they are worried about recent reports on these medicines? Read Glitazones Benefits Versus Risks on the Pulse website for more information http://tinyurl.com/5tdw8k
- Read the article Self-monitoring of glucose by people with diabetes on the BMJ web site www.bmj.com/cgi/content/full/314/7085/964 Think how you could use this information to discuss with your patients the usefulness of self-monitoring.

Evaluate

- Do you now have a sound knowledge of the newest treatments for type 2 diabetes? Are you familiar with their advantages and disadvantages? Could you advise patients on these drugs and confidently discuss the merits of self-monitoring blood glucose with them?

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What does 2009 hold?

It's the time of year when **Gavin Atkin** dusts off his crystal ball to predict the 14 most likely drug launches for 2009

The beginning of the year is a time for many things – celebrations, perhaps; quiet reflection on the year just past; and eager anticipation of the year to come. Hopefully we've enjoyed the first of these two, but what about the third?

In the pharmaceutical market, with all the talk of thin drug pipelines and a lack of blockbusters ready to go straight onto the FP10, you might think there was nothing new in prospect.

Happily, it's not entirely true: it's clear there are some interesting new products just around the corner, and those in the know say there's every chance more treatments will come through in 2010 and 2011. In particular, the big effort that went into biotechnology over the past decade seems to be about to bear some useful fruit.

Few know more about the upcoming drugs than Katrina Simister, managing editor of the National Prescribing Centre's New Medicines programme. "Quite a lot of what's in the pipeline is aimed at immune system conditions, but the really big area is oncology. It's really exciting: researchers have focused on specific sites in tumour cells, and now a raft of new treatments is coming to market."

"Some of them will also move from one disease to another. A drug developed for one disease may be effective in treating another. For example, some of the new psoriasis treatments will also be used in rheumatoid arthritis," says Ms Simister.

All of that said, what can we actually look forward to in 2009?

1. Grass pollen immunisation

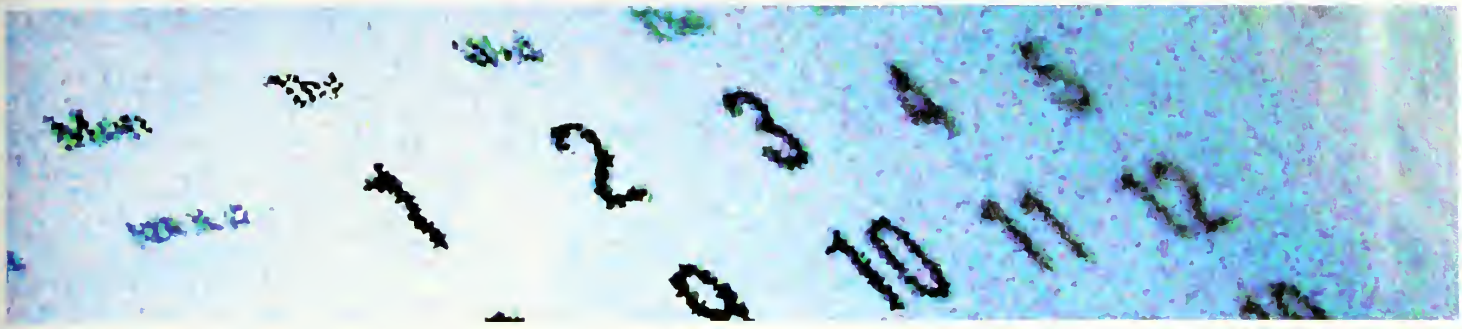
On the allergy front, a strong candidate for this coming year appears to be Allergy Therapeutics' Pollinex Quattro Grass. Results from a phase III study showed the treatment works through the entire pollen season and improves patients' quality of life.

2. Nasal fentanyl-based pain relief

Archimedes Pharma earlier this year announced good phase III results for a fentanyl citrate nasal spray, developed to provide fast and convenient treatment for breakthrough cancer pain. NasalFent showed pain relief five minutes after treatment and proved highly acceptable to patients.

3. Long-acting bronchodilator for COPD

Forest Laboratories has been posting good results from phase III studies of aclidinium bromide, a novel long-acting inhaled



anticholinergic for the treatment of patients with COPD.

4. Platelet level booster

GSK is very excited about eltrombopag (Promacta), an oral medication that increases platelet production. In November, the FDA granted eltrombopag approval for use in thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenic purpura (ITP) following an accelerated approval process.

5. Wide-ranging pneumococcal vaccine

Another candidate from GSK for the near future is a paediatric pneumococcal vaccine, Synflorix, which offers protection against three additional pneumococcal strains – 1, 5 and 7F – that are not currently preventable using a vaccine. These strains are said to account for between five and 25 per cent of all cases.

6. Extended release restless legs treatment

GSK's withdrawn application for its Solzira gabapentin enacarbil extended release tablet for moderate-to-severe restless legs syndrome is very likely to be back on the agenda, the company has said. Solzira offers improved pharmacokinetics compared with conventional gabapentin treatment.

7. Antiplatelet agent

Daiichi Sankyo and Eli Lilly have confirmed they are still confident in the risk-benefit profile of their investigational antiplatelet agent prasugrel, which is being developed for treating patients following percutaneous coronary intervention.

8. A new weapon against nail fungus

Nail fungus has long been a particularly difficult problem, not least because oral treatments can have severe side effects. However, Moberg Derma's K101 experimental treatment for onychomycosis penetrates the nail plate and is applied once-daily.

9. A diabetes drug that doubles as an obesity treatment

The diabetes specialist Novo Nordisk says its GLP-1 analogue diabetes drug liraglutide, which works by stimulating release of insulin only when glucose levels become too high and by inhibiting appetite, is likely to be launched during this coming year.

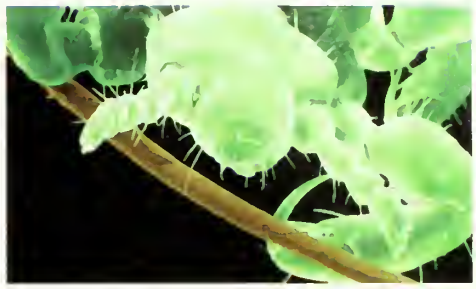
10. Abuse-resistant formulation of oxycodone

Developed by Pain Therapeutics and marketed by King Pharmaceuticals, Remoxy is a controlled-release oxycodone formulation that resists dissolution in alcohol, and prevents the 'dose-dumping' effect that causes the euphoric high sought by drug abusers.

11. Rheumatoid arthritis drug that halts progression and offers disease remission

Tocilizumab (RoActemra) is a humanized interleukin-6 (IL-6) receptor-inhibiting monoclonal antibody that works by suppressing IL-6 activity, which is an important trigger of the inflammatory process. Used with methotrexate, it is claimed to significantly inhibit structural damage to joints in rheumatoid arthritis, improve physical function and significantly increases remission rates. The treatment is being developed by Roche and Chugai.

12. A novel head lice treatment



Viq from Sciele Pharma is an easy-to-use, water-based, water-soluble gel, similar in consistency to a hair conditioner. Unlike many existing treatments that rely on a neurotoxic pesticide, Viq contains a monhydric aralkyl alcohol that causes asphyxiation by preventing the insects from closing their spiracles.

13. Anticholinergic treatment

Glycopyrrolate, also from Sciele Pharma, is an orphan drug and a novel treatment being developed for use by paediatric patients with chronic, moderate-to-severe drooling due to cerebral palsy, mental retardation or other neurological conditions.

14. A novel treatment for gout

Pegloticase is a pegylated recombinant mammalian urate oxidase developed for use in treating gout symptoms in patients who fail to respond to allopurinol, or who are unable to take the established treatment. It is currently being reviewed by the FDA, and is being treated as a high priority by the licensing organisation.

POM to P

Applications to reclassify medicines from POM to P currently in consultation or before the MHRA

- Tamsulosin capsules (Flomax relief) for functional symptoms of BPH
- Cystobid (nitrofuratoin) 100mg capsules for uncomplicated acute bacterial cystitis
- Cyklo-f 500mg tablets (tranexamic acid) for menorrhagia
- Cysticlear (trimethoprim) tablets for uncomplicated acute bacterial cystitis

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A Practical Approach — Heartburn

David Spencer, pharmacist at the Update Pharmacy, is out for a meal one evening with his friend Brian. While they are having coffee, Brian clasps his hand to the middle of his chest and winces.

"Are you okay Brian?" David asks.

"Yes, it's just this heartburn. I was going to ask if you could recommend something for it, actually."

"Are you sure it's just heartburn?"

"Oh yes, I've been getting it off and on for years. But I must admit it's been getting worse in the last year. I get it a few times a week now, and sometimes it wakes me in the night."

"Do you have any problems or pain swallowing food?" asks David.

"No," Brian replies.

"Are you bringing up blood or passing unusually dark motions?"

"Of course not, I'd be straight down to the doctor if so."

"You've put on a bit of weight lately," remarks David.

Brian replies: "Yes, since I've become a partner in the firm I have to do a lot of business entertaining. And I'm not getting the time for exercise that I used to."

"What about drinking?"

"We have wine with these business meals, but otherwise I just drink moderately, as you know. But I'll tell you what does worry me a bit: I've had this irritating dry cough on and off for months. And before you ask, I'm not taking any medicines for it or for anything else, except antacids for the heartburn. Do you think I should see the doc about the cough?"

Questions

1. Should David advise Brian to see his doctor immediately? If yes, why; if no, why?
2. How effective are OTC remedies for heartburn?
3. What factors can contribute to heartburn symptoms?
4. As well as avoiding or reducing the factors listed above, what other measures can help?

Answers

1. No. Gastro-oesophageal reflux disease (GORD), which produces chronic heartburn symptoms, is common (up to 20 per cent in the general population and higher in middle aged and older people). It is not usually serious. Chronic cough and laryngitis occur quite frequently as a result of reflux. As long as heartburn symptoms do not appear for the first time in middle age and there are no alarm symptoms (dysphagia, gastrointestinal bleeding appearing as dark tarry stools, and weight loss) symptomatic treatment can be tried.
2. At prescription doses, the PPI omeprazole has been found to be more effective than H_2-antagonists (famotidine, ranitidine) and both are superior to placebo.[1] There appear to have been no comparisons between these and antacid/alginates, but the latter have been shown to be more effective than placebo.
3. Fatty, fried and acidic foods, caffeinated drinks, alcohol, chocolate, smoking, being overweight.
4. Eating smaller and more frequent meals; avoiding lying down after meals; for night symptoms, not eating within three hours of bedtime, elevating the head of the bed; avoiding tight-fitting clothing.

1. Khan M et al. Cochrane Database of Systematic Reviews 2007, Issue 2

This article can help in the following CPD competencies: **G1a, G1c, G1d, G2o, C1a, C1f.** See http://tinyurl.com/68ox7b

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The next generation

From day one of his career, it was clear Ravi Patel was no ordinary employee. **Tom Hawkins** talked to C+D's Pre-registration Graduate of the Year 2008

C+D AWARD WINNER

Ravi Patel describes his first 24 hours as a qualified pharmacist "as a different kind of day". Different indeed. After four years of study, 12 months as a pre-reg and 48 hours with a certificate from the RPSGB, the first day of Mr Patel's chosen career was spent in the company of the Society's president, competing to become the face of the profession in the Rx Factor competition.

It's not a start that most pharmacists are familiar with, but then much about Mr Patel's fledgling career has been out of the ordinary. In a whirlwind year, he began life as a locum, become the author of a blog on the C+D website, put the RPSGB president and chief executive under the spotlight in a Question Time themed event, and been crowned C+D Pre-registration Graduate of the Year.

One of six pre-reg students to be nominated by Day Lewis for the C+D Awards, he was not confident of his chances. He prepared his entry within four days at a time when he was preoccupied with his forthcoming exam and felt he did not have a single, significant achievement that would make him stand out from the crowd.

"You don't know what anyone else has done. They could have saved a life," he says.

But his modest outlook belies an impressive list of achievements that have benefited colleagues, pre-reg peers and patients, and led to the nomination from his pre-reg tutor Lucy Dean.

In reflection of the rapport that he developed with patients during his time at the Day Lewis shop in Biggin Hill, Kent, his award entry included glowing testimonials infused with references to a personal but professional approach. One methadone patient provided a particularly powerful endorsement: "Coming off heroin has been a very difficult task, but my determination and willpower have been accelerated due to people like Mr Patel, who cares and show they care."

One of Mr Patel's major achievements was to organise a tea dance in association with pharmacy staff and the local Christian Fellowship to address the healthcare of the town's elderly population. He negotiated the provision of tea and cakes from the local Waitrose and hosted around 50 guests on a Saturday afternoon, providing blood pressure checks, weight measurement and lifestyle advice to the assembled group.

He says: "I wanted to promote healthcare and do it in a fun way that's never been done before."

His effort to promote better healthcare among the community also extended to MURs. One elderly woman was so touched by the time and effort he took in showing her how to use her blood glucose meter strips, that she made a batch of muffins for him on a weekly basis and a cake for his birthday.

His influence increased MUR numbers by over 50 per cent but, as a pre-reg, he was excluded from receiving any financial reward. Deeming this unfair, he took the matter to the company's chief executive, who agreed to extend the scheme to pre-regs across Day Lewis. Mr Patel insists, however, that it is the patients rather than the financial incentive that is the real motivating factor in MURs.

"There are ones where you think 'wait a minute'. One patient was taking co-codamol and loads of paracetamol and you realise they would never have known [the problem with] that. When it goes right, you realise what your profession entails," he says.

Mr Patel's influence on company operations extended beyond MURs. He also put his name to a 30-page audit of his shop's prescription collection service that was picked up by head office; he rewrote the SOP for controlled drugs to reflect new regulations; and he also undertook a major project with department heads, warehouse staff and a number of shops to improve Day Lewis's internal mail system.

Recognised by the C+D Award, Mr Patel is now a locum, eager to establish himself in the profession and one day own his own pharmacy. Given his start, few doubt he will achieve it.

"I guess it's personal. If you want to do something, you will," he says. "When you achieve a goal, it makes you do something more."

Ravi Patel file

Name: Ravi Patel

Pharmacies: After starting off with Day Lewis in Biggin Hill, Kent, he is now working as a locum

Award won: C+D Pre-registration Graduate of the Year 2008

Award entry: Mr Patel organised a tea dance for local elderly relatives, with a weight and blood pressure check thrown in; increased MUR numbers; reorganised Day Lewis's internal mail system, rewrote the Day Lewis SOP for controlled drugs; and even managed to get pre-regs included in the staff bonus scheme.

Entries for the **2009 C+D Pre-registration Graduate Pharmacist of the Year** category, sponsored by Reckitt Benckiser Healthcare, are now open. Go to **www.chemistanddruggist.co.uk/awards** for full entry details, hints and tips, online entry or to download an entry form.

RECKITT BENCKISER HEALTHCARE

Cool addition from Mentholatum

Deep Freeze Cold Spray has been launched by Mentholatum. It is presented in a brushed aluminium can with a chunky activator button, designed to be easy for cold, wet or muddy sports players and elderly users to operate.

The product can be used to relieve pain from strains and sprains in muscles and joints. On pack, the familiar Deep Freeze logo is reinforced with a 'Freezes pain instantly' message.

Mentholatum is claiming the new product has been shown in lab tests to be colder and to cool faster than main competitor products.

Price: £3.40/150ml
Pip code: 342-9529
Laser Healthcare
Tel: 01202 780558

Try a boost of juicy energy

Gluco Juice is a new entrant in the energy category. Launched by BBI Healthcare, the product is targeted at diabetics, sports and fitness enthusiasts and those with a busy lifestyle.

Two flavours – raspberry burst and lemon and lime – are available, supplied in a 59ml bottle providing 15g fast-acting carbohydrate. The drink is non-carbonated and easily digested during sporting activities, says BBI.

Supporting the launch is a consumer magazine campaign. Point of sale materials are available comprising wobblers and leaflets.

Gluco Juice joins BBI's existing Gluco Tabs glucose tablets on shelf.

Price: £1.59/59ml
Pip codes: raspberry 339-9805; lemon and lime 339-9797
Cedar Health
Tel: 0161 483 1235

Night Nurse is back

Cold and flu treatment Night Nurse is being advertised on television in a £1.2 million campaign that will be running until mid-February.

Viewers will see the familiar 'Rainswept' ad featuring a cold sufferer going home in miserable weather. Music is provided by the reggae hit 'Night Nurse'.

The ad's key message is 'Night Nurse provides powerful, complete night-time cold and flu relief' and the strapline reads 'Nurse it better with Night Nurse', says manufacturer GSK.

Related point of sale materials are available.

Product info:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Lipobind weighs in

A 'seven figure through-the-line marketing campaign' for weight management supplement Lipobind is underway, reports manufacturer Goldshield.

Running until March with a 'find your true form' theme, the campaign is said to celebrate the beauty of real women through television and print advertising, PR, direct marketing and point of sale materials.

Support for the pharmacy trade includes the recently launched pharmacy training website designed to teach pharmacy assistants about weight loss and Lipobind.

Product info:
Ceuta Healthcare
Tel: 01202 780558
www.pharmacy-skills.com

Cura-Heat's cure all

A new television advert for Cura-Heat is promoting the back, knee and neck variants, reports manufacturer Kobayashi.

Continuing for three months, the campaign is part of a £1 million investment in the brand this year.

The 20-second creative shows three 'young at heart' adults using Cura-Heat products to help them counter pain and let them live their lives to the full. 'Get on with life' is the tagline summing up the advert's message.

It is showing on national stations including ITV1, Channel 4, five and satellite channels.

Product info:
Kobayashi Healthcare Ltd Europe
Tel: 0208 987 9976

By gum, it's Corsodyl

Oralcare brand Corsodyl is gracing television screens with a return of its 'Gorgeous' creative. It will run nationally from January 12 until February 16.

The 20-second ad uses an attractive woman revealing a gap in her teeth to convey its message that 'Corsodyl Mint Mouthwash is clinically proven to help treat gum disease', which is a leading cause of tooth loss. A 10-second tag promotes Corsodyl Daily Defence as providing daily protection for healthy gums, says manufacturer GSK.

Product info:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

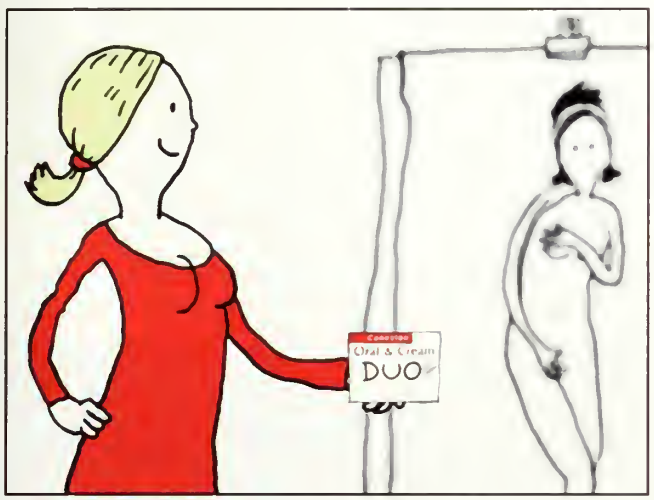
Get animated about thrush

Canesten Duo returns to television screens this month to teach consumers about its dual approach to treating vaginal thrush.

Running from January 12 until the end of March, the 'Show and tell' creative features an animated female character using a flip chart to explain how Canesten Duo – comprising an oral capsule and external cream – works. It ends with the 'Cools and clears' message.

Manufacturer Bayer is hoping for a repeat of the uplift in sales that were seen when the ad last ran.

Product info:
Bayer Consumer
Tel: 01635 563000



Triple TV turn for Aquafresh brand

Oralcare brand Aquafresh is set to benefit from a triple boost of television advertising.

Backing the children's variants, the Nurdle Schmurdle campaign returns, running each evening on the Cartoonito Channel. The advertising has won media awards and helped Aquafresh claim the number one spot in the children's oralcare category (source: AC Nielsen value sales MAT November 22, 2008).

Support for Aquafresh iso-active gel toothpaste began last week with an airing of the 'Aquafresh Amazing' creative, while January 12 sees the appearance of the 40-second 'Possibilities' ad to reinforce the Aquafresh brand equity, says manufacturer GSK.

The creative charts the development of the mouth from infancy to adulthood and conveys the brand's triple protection position.

The TV advertising during January alone represents an investment of more than £2 million, reports GSK.

Product info:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Sensodyne lets the public do the work

The new year sees support for GSK's Sensodyne brand continue with a £10 million TV investment for 2009.

Beginning on January 12, a series of testimonial ads for Sensodyne Total Care F will run intermittently through to June. Members of the public will be seen explaining how Sensodyne Care F has helped them find relief from sensitive teeth.

Over the course of the year, advertising for Sensodyne Pronamel will broach the subject of acid erosion.

Product info:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Nutrition Point beats the deadline

Bringing you the best in Gluten-free

ds
TRUfree
Glutafin

Nutrition Point, owner of the Glutafin, Dietary Specials and Trufree brands, has said all its products comply with new criteria regarding gluten-free labelling.

The company has come into line with the new Codex Standard and EC legislation three years ahead of the January 1, 2012, deadline.

Under the new EC legislation, for food to be labelled gluten-free it must contain no more than 20ppm gluten. Products containing 21 to 100ppm can be labelled as very low gluten.

The previous Codex Standard said gluten-free products should contain no more than 200ppm gluten.

Product info:
Nutrition Point
Tel: 0800 988 2470
glutenfree@glutafin.co.uk

For on TV this week see:
www.chemistanddruggist.co.uk/prodnews

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We are currently offering free online recruitment advertising at www.chemistanddruggist.co.uk/jobs

Call Jonathan Paul Franklin on 020 7921 8333 today to find out how C+D can improve your recruitment prospects

Looking for a new job? Got a staff problem? C+D's new weekly careers section is your one-stop guide to making the right decisions

How to be a CPPE tutor

C+D's **Asha Fowells** describes her experience as a new CPPE tutor

There must be many pharmacists out there like me. I'm a community pharmacist – though I've been working at C+D for the last few years – and while my work is challenging and interesting, I'm always on the lookout for that extra something to push me that bit further.

So when I found out the Centre for Pharmacy Postgraduate Education (CPPE) needed a new tutor for Croydon, I thought I'd find out more. A few emails later and I found myself filling in an application form, then going up to Manchester for an interview (CPPE is based at the University of Manchester).

Just an hour after the interview, my mobile rang. I accepted the offer of the position, then sat back, thinking: "Oh no, now I've got to actually do the job!"

Any concerns I had about joining the ranks of CPPE tutors were compounded only a few days after starting, when I was inundated with emails and post. Had I booked events for my area for the spring term? Um, no, I had no idea where to start with that. Had I booked onto the CPPE national meeting? No to that as well; I didn't even know when it was. And so on.

And then I discovered three wonderful things: (1) CPPE HQ staff are always happy to help; (2) no question is too minor or ridiculous to be answered, and – best of all – (3) emails are responded to at lightning speed. A couple of weeks later, after I'd been sent the CPPE tutor manual and handover notes from the previous tutor, I'd managed to organise two events for the spring term and was feeling very proud of myself.

Things only got better when I went to the two-day national meeting. Attended by every CPPE employee, including HQ staff and all tutors, it was a brilliant opportunity to meet lots of new people and find out what we'd be expected to do over the next few months. And there were plenty of other new tutors, who had the same questions and concerns as me (all of which were answered).

Another couple of months on and it's all going well. As well as organising and facilitating events (which are incredibly rewarding), I've made myself known as the local face of CPPE by meeting with the LPC, RPSGB branch, and PCT.

You don't have to be incredibly clever or a clinical expert to be a CPPE tutor (which is a relief, as I'm neither). But you do have to have a good memory, and be efficient and organised.

Other than that, there doesn't seem to be a profile for a typical tutor. In fact, the wide variety of backgrounds – the vast majority of tutors do the role on top of one or more other jobs, which range from community and PCT positions to working in hospitals and academia – is one of the strengths of CPPE. If you ever have a question, someone, somewhere will usually know the answer, or be able to point you in the right direction.

Knowing how to use the resources available to you: isn't that what being a pharmacist is all about?

What's the pay like?

About the same as locum rates

Interested?

CPPE is currently looking for tutors for:

- Coventry/Warwickshire
- Farnborough/Basingstoke
- Northamptonshire
- North East Lincolnshire
- Southern Cheshire
- South Staffordshire

For more information, email CPPE deputy director Matthew Shaw at matthew@cppe.ac.uk or telephone 0161 778 4000.

CAREER TIP of the week

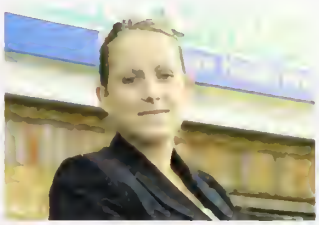
"Do not pretend that you are not dependent on your key staff. It is certainly true that no-one is indispensable, but do not try to minimise the value of your key staff"

from Brilliant Manager, by Nic Peeling
www.chemistanddruggist.co.uk/booksforjobhunters

Your QUESTIONS answered

How can I keep my technician?

Q One of my technicians has been approached about a position in a local hospital. She was not looking to leave but is now considering it as they are promising her a career pathway. What can I do to keep her?



Numark training manager Jane Lumb (pictured) responds:

A There has always been a perception that the money in secondary care is what tempts highly trained staff from community, whereas the reality is just as you describe – more often down to a perceived career path.

The options you have to try to keep her depend on how you see her role developing in the future. Find out what interests her about the position and career path highlighted and see if that is something you could help her get from her current role – maybe she is bored.

Why not think about how you could offer her more responsibility or at least utilise her skills more productively. One option could be to make her responsible for developing and delivering new services in the pharmacy, for example a weight management service.

In a community pharmacy, staff often get more feedback from customers than those working in secondary care, which helps them to feel valued. Believing they can and do make a difference can be very rewarding for them – the key is not losing sight of their development path.

Do you have a career-related question for C+D? Email jrichardson@cmpmedica.com and we'll ask the experts.

C+D

0207 921 8123

Booking and copy date
12 noon Monday prior
to Saturday publication subject
to availability

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Andrew Walker
Chemist+Druggist (Classified),
CMP Medica Ltd
Ludgate House
245 Blackfriars Road
London SE1 9UY

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F: 0207 921 8136

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Recruitment

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*Linda Jones Associates industry survey

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PHOENIX Healthcare Distribution Limited, Whitehouse Industrial Estate,
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scongleton@phoenixmedical.co.uk

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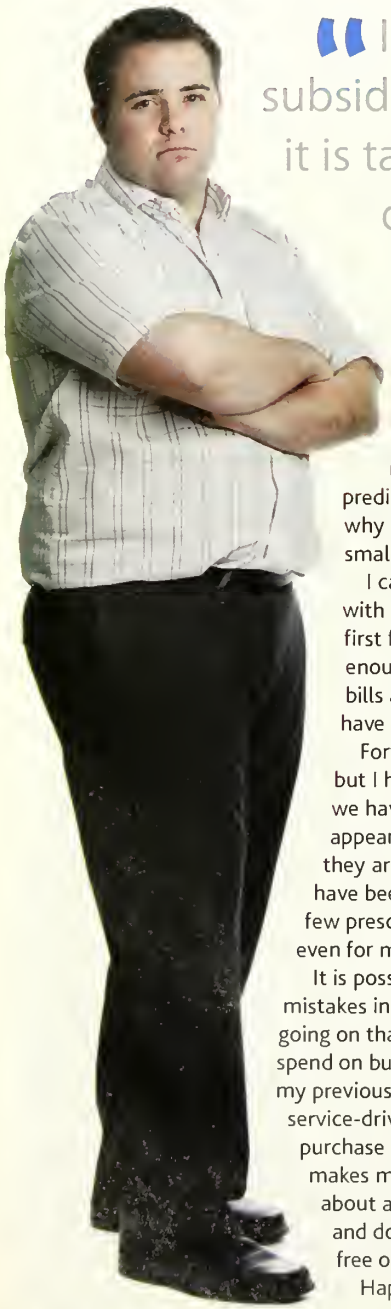
postScript

Open Mike — Mike Hewitson

The not-so-secret diary of a new pharmacy owner

Mike Hewitson is a glutton for punishment. In the midst of economic downturn and with first-time fatherhood looming, Mike has bought his first pharmacy. In this regular column, follow him from his former home in Cheltenham to Beaminster Pharmacy in deepest, darkest Dorset, and Mike will reveal the fears, frustrations and step-by-step successes of a new pharmacy owner.



> "It appears I am subsidising the NHS, as it is taking back more discount than I received this month!"

You can't turn on the news at the moment without hearing gloomy predictions for 2009. And it's easy to see why people are scared. As the owner of a small business, I'm scared!

I can't say that I'm overly impressed with my NHS payment this month. Our first full cheque should provide us with enough money to pay off our wholesale bills and remunerate us for the service we have provided.

Fortunately, we cover our wholesale bill, but I have to laugh at the supposed fortune we have made in professional fees. It appears that I am subsidising the NHS, as they are taking back more discount than I have been given for the month! Throw in a few prescription switches and we're about even for month one.

It is possible that I made a few purchasing mistakes in my first month – there was so much going on that I didn't really have the time to spend on buying correctly. And, as I learnt from my previous employer, despite all of the talk of service-driven remuneration, it is still the purchase profit that pays the bills. Which makes me even more cross when I think about all of the services that pharmacies up and down the country are offering to PCTs free of charge.

Happy New Year!

Curveball

Postscript is relieved to see the Pope is still alive and well, despite concerns raised in the BMJ.

Noting that rugby union is followed religiously in Wales, a team from Cardiff University investigated the correlation between Welsh grand slam victories in the Six Nations tournament and papal demise.

The evidence was compelling: the previous three Popes have all died in a year when Wales won a grand slam (two dying in 1978, when Wales were really good). Fortunately for current pontiff Benedict XVI, there was no evidence that Welsh rugby victories increase the chance of smoke puffing out of the Vatican chimney.

The news no doubt comes as a relief to a Wales side chasing a consecutive Six Nations title – especially to Gavin Henson, who already has one Church to worry about...

New for 2009

PostScript is delighted to welcome Chris Chapman to the C+D editorial team. Chris joins C+D as a reporter.

Chris initially trained as a pharmacist and, after pre-registration placements with both Tesco Pharmacy and Scarborough General Hospital, graduated from the University of Bradford in 2006.

However, he decided not to sit the pre-reg exam and instead joined The Practitioner, a monthly clinical journal for GPs. After two years as a sub-editor and most recently assistant editor, he has now returned to his pharmacy roots with C+D.

To contact Chris with your stories or comments, send him an email at cchapman@cmpmedica.com or give him a ring on 01732 377503.

Web comment of the week

Government abandons bid to curb dispensing GP powers
Posted by Dany Ros on 20/12/2008, 11:15

> What a **surprise**! Another case demonstrating the strength of the GPs' **lobbying**... I wonder whether the **outcome** would have been the same if it had been the **other way** round?

Have your say on C+D's website
register for free at www.chemistanddruggist.co.uk/register

**What have you and your team been up to lately?
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Email postscript@cmpmedica.com**

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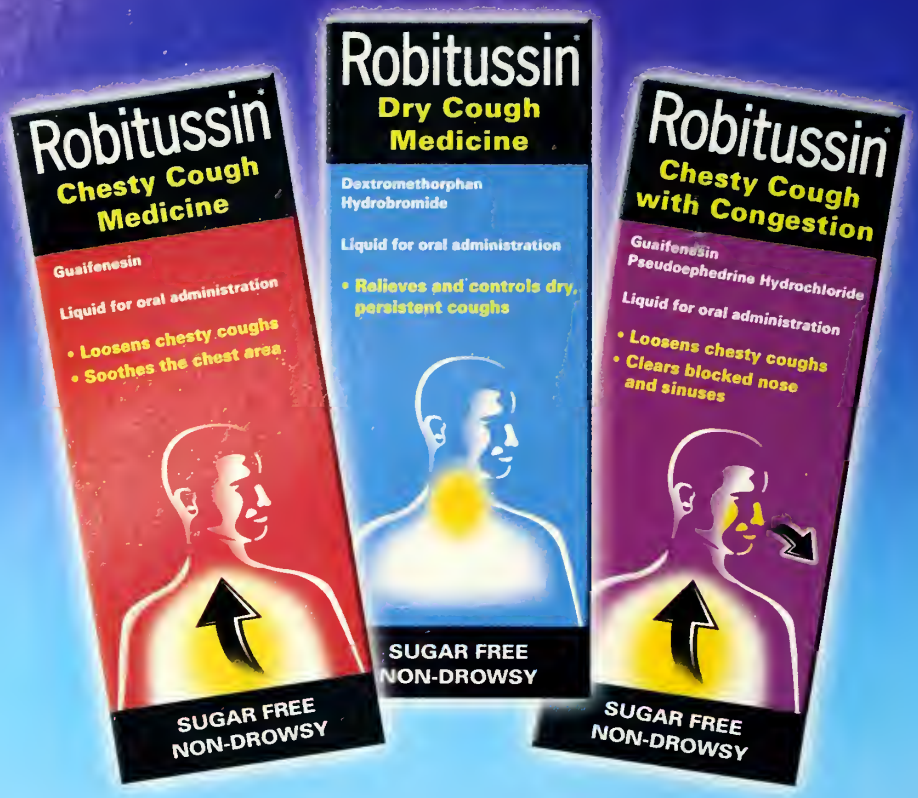
INTRODUCING THE NEW Robitussin* PACKAGING



Updated look whilst retaining strong colours and clear graphics

Revised paediatric dosing in line with MHRA recommendations

Clear labelling of the sugar free, non-drowsy benefits

On-pack information on symptoms and the importance of adhering to dosage instructions

* Trade Mark

FEEL CONFIDENT TO RECOMMEND *ROBITUSSIN* - EXCLUSIVE TO PHARMACY

RDBITUSSIN* CHESTY COUGH MEOICINE.

Name of product: Robitussin Chesty Cough Medicine. **Active ingredient(s):** Guaifenesin Ph Eur 100mg. **Product licence number:** PL 00165/0097. **Name and address of the product licence holder:** Wyeth Consumer Healthcare, SL6 OPH. **Supply classification:** P. **Indications:** Expectorant for the treatment of coughs. **Side Effects:** Nausea, vomiting, hypersensitivity reactions. **Contra-indications:** Hypersensitivity to any of the constituents. Use in children under 2 years. Use in combination with other cold, flu or decongestant products in children under 6 years of age. **Interactions:** None known. **Pregnancy and lactation:** The potential benefit of treatment should be balanced against any possible risks. **Effects on ability to drive and use machines:** No or negligible influence. **Dosage:** Adults, the elderly and children over 12 years: One 10ml measure up to four times daily. Children: 6 – 12 years: One 5ml measure up to four times daily. 2 – 6 years: One 2.5ml measure up to four times daily. **Warnings:** Causes of chronic cough should be excluded if symptoms are persistent. Accompanying symptoms should be actively sought and treated. Patients with rare hereditary problems of fructose intolerance should not take this product as it contains Sorbitol and Maltitol. This product contains Amaranth (E123) which may cause allergic reactions. This product also contains small amounts of ethanol (alcohol), less than 100mg per 5ml dose. **Cost:** Amber plastic bottles of 100ml RRP £3.85. **Date:** June 2008.

ROBITUSSIN* CHESTY COUGH WITH CONGESTIDN MEDICINE.

Name of product: Robitussin Chesty Cough with Congestion Medicine. **Active ingredient(s):** Guaifenesin Ph Eur 100mg, pseudoephedrine hydrochloride BP 30mg. **Product licence number:** PL 00165/0098. **Name and address of the product licence holder:** Wyeth Consumer Healthcare, SL6 OPH. **Supply classification:** P. **Indications:** Nasal decongestant and expectorant for the symptomatic relief of respiratory tract disorders. **Side Effects:** Symptoms of central nervous system excitation may occur (sleep disturbance and, rarely hallucinations). Skin rashes with or without irritation, and urinary retention. **Contra-indications:** Hypersensitivity to any of the ingredients. Use in patients with ischaemic heart disease, thyrotoxicosis, glaucoma, diabetes, enlargement of the prostate or urinary retention. Patients currently receiving or who have within two weeks received, monoamine oxidase inhibitors. Patients receiving tricyclic antidepressants. Patients receiving other sympathomimetic drugs. Use in children under 2 years of age. Use in combination with other cold, flu or decongestant products in children aged 2 to 6 years of age. **Interactions:** Cardiac arrhythmias have been reported if given to patients receiving cardiac glycosides. May increase blood pressure and therefore special care is advisable in patients receiving antihypertensive therapy. **Pregnancy and lactation:** Not to be used in pregnancy unless on the advice of a doctor. **Effects on ability to drive and use machines:** None stated. **Dosage:** Adults the elderly and children over 12 years: One 10ml measure up to four times daily. Children: 6-12 years: One 5ml measure up to four times daily. 2-6 years: One 2.5ml measure up to four times daily. **Warnings:** Not to be taken by patients taking either cardiac glycosides or anti-hypertensive agents, except on a doctor's advice. Not to be given to children under 6 years of age unless directed by a doctor or pharmacist. **Cost:** Amber plastic bottles of 100ml RRP £3.85. **Date:** January 2008.

ROBITUSSIN* DRY COUGH MEOICINE.

Name of product: Robitussin Ory Cough Medicine. **Active ingredient(s):** Oextromethorphan hydrobromide Ph Eur 7.5mg. **Product licence number:** PL 00165/0100. **Name and address of the product licence holder:** Wyeth Consumer Healthcare, SL6 OPH. **Supply classification:** P. **Indications:** For the relief of persistent dry irritant coughs. **Side Effects:** Gastrointestinal upset, dizziness. **Contra-indications:** Hypersensitivity to any of the constituents. Use of a monoamine oxidase inhibitor (MAOI) or for 14 days after stopping the MAOI drug. **Interactions:** Risk of hyperpyrexic crisis when MAOI are taken in combination with dextromethorphan. Amiodarone and quinidine can increase serum concentrations of dextromethorphan. **Pregnancy and lactation:** The potential benefit of treatment should be balanced against any possible risks. It is not known whether dextromethorphan or its metabolites are excreted in human milk. **Effects on ability to drive and use machines:** No or negligible influence. **Oosage:** Adults: 10ml three or four times daily. Children 6-12 years: 5ml three or four times daily. Children under 6 years: Not recommended. **Warnings:** Patients suffering from chronic cough, asthma or patients suffering from an acute asthma attack and any accompanying symptoms should be actively sought and appropriately treated. Use with caution in patients with hepatic dysfunction. This product contains Amaranth (E123), which may cause allergic reactions. This medicine contains small amounts of ethanol (alcohol), less than 100mg per 5ml dose. Patients with rare hereditary problems of fructose intolerance should not take this medicine because this product contains Sorbitol and Maltitol. **Cost:** Amber plastic bottles of 100ml RRP £3.85. **Date:** May 2008.